The Chief Registrar role in the UK

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Introduction

Encouraging medical leadership is a goal for policy makers and professional organisations across the world. Of the many debates concerning medical leadership, a key one for both immediate practice and future development is how doctors in training are engaged in leadership and specifically service improvement, and how they may be developed for future leadership roles. It has been argued that junior doctors have the skills and opportunities to contribute to service improvement, but that this opportunity is often missed. (Brown *et al.,* 2012, Ibrahim *et al.,* 2013, The Health Foundation 2011, Gilbert *et al.,* 2012).

The Royal College of Physicians (RCP) in the U.K. developed a Chief Registrars programme in 2016 as part of an initiative to support the development of acute hospital services. This paper reports on the evaluation of the pilot scheme in the UK in 2016/7 which included 21 Chief Registrars in medical specialties in England, Wales, and Northern Ireland (Exworthy and Snelling 2017). Within the organisation of hospital medical training in the UK, the Registrar title describes specialist training posts that culminate in eligibility for Consultant posts. The term is widely used although formally it has been replaced by 'Specialist Trainee'. Described as 'unsung heroes' (Royal College of Physicians 2013a), Medical Registrars are both trainees and senior doctors, with the balance changing as training progresses over up to 8 years (full time equivalent), depending on specialty. Although there has recently been a number of opportunities for doctors in training to access development in management and leadership (Aggarwal and Swanwick 2015) these have often been either dedicated Fellowships undertaken outside of a medical training post, or a more limited opportunity within training (a 'course').

The distinctiveness of the Chief Registrar programme is that the post holders remain in clinical practice (Phillips 2018) for its duration of one year in most cases, which is not the case for a number of other leadership fellowships that are available in the U.K. There is a requirement that the role devotes at least 40% of the working week to the Chief Registrar role, with the remainder in the medical registrar role. A Chief Resident programme was established at Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's) in 2010, but without dedicated time in the leadership role (Hofmann and Vermunt, 2017). 'Resident' is a term equivalent to 'Registrar', especially in the American system. Perhaps the most high-profile Fellowship scheme in the UK is the Darzi Fellowship, a year long development programme established in 2008, that specialist trainees take in a break from their clinical training. This scheme has recently become multi-professional (Stoll *et al.,* 2011, Conn *et al.,* 2016). Similar schemes have been established elsewhere in the U.K., in Wales (Bullock and Phillips 2014), Scotland (Pearson et al 2018), and Northern Ireland (Donaghy *et al.,* 2016). In the North West of England doctors have joined NHS Graduate Management Training Scheme trainees (Agius *et al.,* 2015). Bagnall (2012) interviewed participants on the Darzi and North-West schemes and others in England, and confirmed the broadly positive evaluations that the schemes have received. However, there is little mention in the evaluations of any clinical roles that were undertaken in the Fellowships, or how they interacted with the learning about leadership. Unlike other fellowships, the Chief Registrar posts can be undertaken either within the post graduate medical training programme, or in a break from it, but still in a Registrar role.

There is no literature available on the Chief Registrar role in the UK because it is a new role. In the USA, a role of Chief Resident has been established from at least the early 1990s (Lim *et al.,* 2009, Young *et al.,* 1996, Alpert *et al.,* 1995, Norris *et al.,* 1996). A number of more recent studies have investigated the roles and training of Chief Residents in specific specialties – Family Medicine (Deane and Ringdahl, 2012), Care of Older Adults (Levine *et al.,* 2008), Internal Medicine (Bergh and Huot,

2007), Emergency Medicine (Hafner *et al.,* 2010), Radiation Oncology, (Zaorsky *et al.,* 2013) Paediatrics (Dabrow *et al.,* 2011) and Psychaitry (Lim *et al.,* 2009, Warner *et al.,* 2007). Across these studies, Chief Resident duties involve administration, clinical work and education. In the USA there seems to an emphasis on Chief Residents' roles in leading education and training for doctors, rather than in service improvement, and there is no sense of their being a 'national scheme' as there is now in the U.K.

The context for the scheme.

In September 2013, the RCP published the report from the Future Hospital Commission (Royal College of Physicians 2013b). *Future Hospital: caring for medical patients*, laid out a vision for how hospital services can adapt to meet the needs of patients now and in the future. It included a range of major changes in the delivery of care and the leadership of it, such as commitment to 7 days services and the principle that patients should only be admitted to hospital if their care required it. The report called for improved planning and co-ordination of care in hospital, and between hospitals and the community, with clear clinical leadership of services. The establishment of Chief Registrars was a key element of improved clinical leadership, in support of a Chief of Medicine. "The primary role of ..[the Chief Registrar]..will be to liaise between the junior medical staff working in the Medical Division and the chief of medicine and senior clinical managers responsible for delivery of the service…" (Royal College of Physicians 2013b: 37).It was acknowledged that the Chief Registrar post was a leadership development post, which would have a key role "in planning the workload of medical staff in training, medical education programmes and quality improvement initiatives" (Royal College of Physicians 2013b: 83).

One element of context for the establishment of the Chief Registrar scheme was the contract dispute between junior doctors in England and the government in 2015/6, which resulted in industrial action (Exworthy 2015). After a number of days of strike action in January to April 2016, a contract was agreed. Amongst its requirements was that each relevant NHS organisation set up a junior doctors' forum and appoint a guardian of safe working. The introductions of these forums coincided, in some hospitals, with the introduction of Chief Registrars posts (Iliffe 2016).

As well as specific issues relating to the new contract, junior doctors have been reporting lower levels of morale and higher levels of stress in recent years, a factor which exacerbated the dispute about the new contract, but which predated it. For example, only 44.5% of doctors reported satisfaction with their workloads in 2016. 80% of trainees felt excessive stress because of their job (Health Education England 2017). One in four doctors-in-training report that their role has had a serious impact on their mental health, and seven in ten worked on a rota with a permanent rota gap (Royal College of Physicians 2016a, 2016b). The contract dispute and the generally perceived increase in stress and pressure gave additional important context to the Chief Registrar programme.

The Chief Registrar programme

There were 21 participants in the Chief Registrar programme in the first cohort in 2016. Posts were, in the main, for one year although start and finish times were determined locally. They worked in acute hospital organisations across the UK, with the majority in London and the South of England. The cohort of Chief Registrars were drawn from 9 specialties, with the most common being respiratory medicine. Three organisations had two Chief Registrars, so 18 NHS acute organisations were involved in the programme. The Royal College of Physicians supported the cohort through commissioning a development programme which was provided by the Faculty of Medical Leadership and Management. The Royal College also facilitated action learning sets. Each Chief Registrar had a local mentor appointed by the employing hospital to provide local support. The development

programme consisted of 9 days across four modules, and included the structures of the NHS, links between leadership and clinical outcomes, effective team-working, change management, quality improvement and patient safety, and strategic thinking.

Detailed arrangements for the individual posts were made locally, including how the posts were funded, and how they were recruited to. In some Trusts a Chief Registrar post was available for any eligible Medical Registrar. In others the role was advertised as a specific post, with a particular project in mind. Whether the role was undertaken within the training scheme or in a break from it was negotiated between the individual Chief Registrar and the Training Programme Director. The Royal College of Physicians provided documentation for the recruitment process, including job descriptions.

The Royal College commissioned an independent evaluation of the programme on which this article is based (Exworthy and Snelling 2017). An article was also published in the College publication *Commentary* (Snelling and Exworthy 2017).

Evaluation aims and methods

The aims of the evaluation were to examine the ways in which Chief Registrars were enacting their roles, and to assess the effectiveness of the Chief Registrar role on the individual Chief Registrars themselves, their colleagues, their organisations and their patients. Ethical approval was granted by the University of Birmingham.

We adopted a mixed methods design, comprising a monthly survey and six case studies. All Chief Registrars were asked to complete a short, quantitative monthly survey for the months September 2016 to March 2017, which identified the total time they were able to devote to the Chief Registrar role, the colleagues they were engaging with, and the issues they were working on. Brief qualitative data highlighted achievements and any barriers to progress. Overall, across the seven monthly surveys a 60% response rate was achieved, with all Chief Registrars completing at least one monthly return. The return rate may have been affected by the regular requests and short deadlines which ensured that contemporary data over the 7 months was available. Seven Chief Registrars responded at least 6 times so there is some good continuity of data from a limited sample. Six case-studies were selected, in conjunction with the Royal College to give coverage of different contexts and locations. Two were in London, with 1 each in Wales, Northern Ireland, the Midlands, and the South. Each case-study involved semi-structured interviews with the Chief Registrar and colleagues. Interviewees varied between case-studies as this was decided locally, but included Chief Registrars' mentors, medical directors, heads of education, and junior doctors. They were mostly undertaken face-to-face but if individuals were not available in person, interviews were held by phone.

Interviews lasted approximately 45 minutes. In the 6 case-studies, a total of 6 Chief Registrars and 25 members of their role sets were interviewed in February and March 2017. In addition, two Chief Registrars (from the original case-study sample) were re-interviewed on the telephone in May and June 2017 to update their accounts from the earlier visits. All Chief Registrars not in the case studies were asked for an interview; 9 of the 15 not engaged in a case study were interviewed on the telephone. A total of 42 interviews were conducted in the evaluation. Drawing on the `framework method' (Gale *et al.,* 2013), interview transcripts were analysed using a combination of *a priori* and emergent themes.

Results

The aims of the evaluation are addressed in turn. First some descriptive data on activities are presented. Second, the ways in which the Chief Registrars enacted their roles are explored, and finally some assessment of the effectiveness of the role is given. Quotes are identified by role only: Chief Registrar (CR), Clinical Director (CD), Medical Director (MD), Junior Doctor (JD).

The three role areas that were identified in the Future Hospital report were used in the monthly survey: planning the workload of medical staff in training (considered 'operational issues'), medical education, and service improvement (the term quality improvement is also widely used). Across the whole data set, Chief Registrars gave most attention to service improvement issues (47%) followed by educational issues (27%), operational issues (20%) and others (7%). Operational issues peaked in December, as several Chief Registrars reported becoming engaged in 'winter pressures' and rota issues.

Chief Registrars had an average 53 hours per month available for their leadership roles, and undertook an average 55 hours of Chief Registrar-related work in the role. This includes training which accounted for 20% of Chief Registrar time.

The survey also asked Chief Registrars to quantify who they were engaging with in their role. Just under half Chief Registrar time was spent engaging with trainee doctors (25%) and senior medical staff (21%). However, Chief Registrars also reported working with other groups of clinical and managerial staff. This suggests a wider organisational focus for Chief Registrars than the operations of the Medical Division. There was considerable variation between Chief Registrars' experiences. Table 1 below shows means, maxima and minima for the seven Chief Registrars who completed 6 or 7 monthly surveys.

Table 1 here

This variation reflected the heterogeneous nature of the group. For example, a number of Chief Registrars had a developed interest in management and leadership with, in some cases, prior or concurrent developmental opportunities through fellowships, or academic study. Other Chief Registrars were much earlier in their leadership development. There were also differences in the medical role context of the trainees. Some trainees were in roles which they described as supernumerary because of the proximity of their post to the end of training, or because a new post had been created for the Chief Registrar. These Chief Registrars were able to work flexibly on their role, with limited operational pressure. Others, though, needed to negotiate more difficult operational and cover arrangements, and were less able to work flexibly, which constrained their ability to engage in leadership and management activities.

Against the backdrop of the junior doctors' contract dispute, and public prominence given to the issue of 'rota-gaps' it might be considered that rota issues would have had a major influence on the role, both in terms of allowing Chief Registrars to take their protected time, and for some, the challenges of managing the rota. There was a limited sense that the rota became a concern that overwhelmed other activity. The monthly survey qualitative data did give some examples of short term rota pressures, for example:

"….trying to cover a 25% depleted SHO workforce with the same amount of doctors… inevitably took a lot of criticism.   I spent time on recruiting doctors for this gap, actively arranging meetings to convince doctors to work here" (CR).

Rota pressures also impacted on some Chief Registrars as it required them to cover unfilled gaps. However, it was more common that Chief Registrars were able to avoid these pressures.

1
2
3   The enactment of the role
4
5   The enactment of the role is summarised in 5 sections: the autonomy to develop the role, time and
6   role management, the styles of leadership adopted, experiences, and support. Fuller accounts are
7   available in Exworthy and Snelling (2017).
8
9
10   *Autonomy to develop the role*
11
12   Chief Registrars had significant autonomy about the areas they wished to concentrate on. Instances
13   of a clearly defined role awaiting the new Chief Registrar were rare. Pragmatic local approaches to
14   planning the role were commonly adopted, with roles being fashioned between the incumbent and
15   senior medical leaders. The autonomy and latitude that had been given was welcome to some
16   extent but for others, this created a sense of uncertainty. *"A lot of the time, I suppose the first few*
17   *months of the role, I couldn't justify my existence… I mean I really struggled"* (CR). A number of Chief
18   Registrars felt that the early months of their posts were not as productive as they might have been.
19   A period of about 3-4 months was commonly cited as the time needed to settle into their role and
20   define their purpose and projects. Since the Chief Registrar was a new role, there was a period of
21   engaging with others to introduce and explain the role.
22
23   For some the uncertainty in the first few months was reflected in ambivalence about the title of
24   Chief Registrar. For example, *"I'd worked in the hospital so I knew a lot of the junior doctors anyway*
25   *and I think there was a lot of uncertainty with regards to what a Chief Registrar was. There was a lot*
26   *of mocking the title and no-one really knew what my role was"* (CR). Over time, the uncertainty
27   about the title moderated among Chief Registrars. For example: *"Initially, I was reluctant to own the*
28   *Chief Registrar brand. …. But, actually, increasingly so, I realised that it opens many doors.."* (CR).
29   Senior staff supported the use of the title. For them, it was largely about the authority which the title
30   conferred upon the role. *"The role has to have some authority and I deliberately wanted [the Chief*
31   *Registrar] to use the title"* (MD). A reluctance to use the title and an insistence on it by a Medical
32   Director is summed up in this quote concerning an e-mail signature:
33
34   *"I certainly didn't want to change my emails or my anything to represent it [*Chief Registrar
35   role*] and it was interesting because it was the medical director who eventually just changed*
36   *it for me… I thought `oh, it's true.' That does help you when you're sending emails to heads of*
37   *department and service heads"* (CR).
38
39   In our interviews, we heard little about the link with the Future Hospital Commission Report, or of
40   the posts being part of a strategic change programme, and it seems that although these provided a
41   context for the introduction of the posts, the emphasis was on local flexibility.
42
43   *Time and role management*
44
45   In their role as leaders of junior doctors, there were differences between Chief Registrars in terms of
46   who their 'constituency' was, which seemed to vary on two dimensions. Firstly, whether the role
47   should extend beyond the medical (physician) organisation into other specialties. Second, whether
48   the role primarily related to registrars or to all junior doctors.
49
50   The ease with which Chief Registrars were able to protect their time varied according to local
51   circumstances. In the main, Chief Registrars protected time by having dedicated days for their Chief
52   Registrar role. However, this wasn't always the case. For example, one Chief Registrar said:

> *"There were no dedicated days to do it. I've taken much more of a blended approach to this, where, for example, there might be a meeting in the afternoon or a meeting at lunchtime I go to, but I'm on the wards. Sometimes, obviously…. I need to block some time in the diary to go somewhere or to get some piece of work done or administration"* (CR).

The training context in this case was of a very senior trainee. Having dedicated Chief Registrar days was essential in most cases to maintain the balance between clinical and leadership roles but were also a constraint if, for example, important meetings were missed because they fell on the 'wrong' day.

Styles of medical leadership

Chief Registrars tended to adopt an informal, distributed leadership style, rather than more transactional or transformational ones (Tweedie *et al.,* 2017). One Chief Registrar, for example, said:

> *"I really do not see myself as being some sort of leader, you know, pushing through stuff. I just see myself as somebody who asks questions and, you know, tries to connect things together. Stuff that's already there, where all the good work is."* (CR)

This theme is also considered below in considering processes of engagement and quality improvement. There was an emphasis on relationship building, particularly through face to face conversations, and one Chief Registrar spoke of being in the background, 'nibbling away'.

Two factors were identified to account for the style of leadership. First, as succinctly explained by one of the Chief Registrars: *"There's probably only limited stuff I can do as a trainee, you know, who's here for a year and is not full time to this."* (CR). This sense of limit to the role, combined with the autonomy granted in establishing it, seemed to facilitate and reinforce a leadership style that was distributive and developmental. There was little mention in interviews of short term pressures or preoccupation with targets which might have provided a context for more directive leadership.

Second, a number of Chief Registrars found the nature of the changes they were engaged with required broad consensus with key stakeholders, perhaps somewhat against their expectations: "*It's probably me being a little naïve but, …., even something simple like the triage system was just a lot of hard work in the beginning, you know, once you got the right people on-board it became much easier, but it's just knowing how to do that and knowing who to ask"* (CR).

Experiences in the role

All Chief Registrars spoke of the challenges that they faced during their year. *"I think I would describe it as being sort of a year of highs and lows"* (CR). In the survey, we asked whether Chief Registrars had experienced setbacks. Many reported delays or slow progress in projects, or in establishing the role and its facilities. Time available for the Chief Registrar role was a constraint, especially where there had been absence for study leave. These testing times were broadly divided into two categories: individual and organisational.

Interviews revealed that Chief Registrars often found their role to be daunting as it could be isolating from clinical work, colleagues and peers, and/or ill-defined. Sometimes, this `loneliness' was shaped by naivety in implementing change and in leadership. *"There were times when you felt a little bit out of your depth and therefore it was quite daunting at times because we were trying desperately to achieve something that you saw as very important"* (CR). This had an impact on Chief Registrars' own

morale. *"I think my morale's gone up and down throughout the year as well because at times I found it quite disheartening"* (CR).

Organisationally, Chief Registrars faced the challenge of implementing change in a multi-professional environment. For some, this had a significant impact. *"I think I got a lot of backlash from that [service improvement project] for weeks and weeks and I had to keep my head down at that point and hide if I saw somebody walking down the corridor"* (CR). For others, it gave an appreciation of the scale of the challenge and the timescale involved in bringing about change. For example, one Chief Registrar noted resistance to change. *"I think I struggled at times feeling the resistance out there, so you want to try and move something forward and you just feel this huge wave of resistance or this huge lull in morale that people just can't be bothered!"* (CR).

Support from senior medical colleagues

All interviewees reported that they were well supported by senior medical staff: *"The only reason why it's effective is you have a Medical Director and [a Chief of Medicine]. So probably as far as clinical, as far as hierarchy, they're the two most important people in the hospital and if they champion you, then I think you will do well… With those two, it made a massive difference"* (CR).

The support from mentors in the Chief Registrar's organisation was widely welcomed as guiding and coaching them through the organisation's decision-making. *"I had the Deputy Medical Director who was absolutely excellent and I couldn't have asked for a better mentor. .. I had monthly meetings with her. She's obviously extremely experienced and has done a lot of coaching work ….., so there was an extremely supportive relationship from my perspective"* (CR). For others, the support was more local, embedded in the clinical team of the organisation or the projects that the Chief Registrar was working on.

The effectiveness of the role

In this section, we explore the primary activities and projects which the Chief Registrars undertook as well as views on outcomes of the programme. As noted above the Chief Registrars had significant autonomy in the way that their roles developed, including in the areas in which they worked.

Table 2 below shows examples of projects relating to the three areas considered in the Future Hospital Commission report and the survey data: 'operational issues', medical education, and service improvement. The data came from the monthly survey returns of the Chief Registrars.

Table 2 here

A number of Chief Registrars were able to engage trainees in service improvement projects, either directly or through working with other junior doctor leaders with a specific interest in service improvement. In some cases, the existing culture of the organisation supported the engagement of junior doctors in quality and safety improvement. One organisation, for example, had developed a Junior Doctors' Safety Board. Few mentioned a specific approach or methodology in their QI work. Much of their work centred on organisational change and implementation. Some Chief Registrars became a generic source of QI advice and some were involved in developing a `QI culture' in the organisation, for example in advising and supporting QI projects led by other staff.

A key theme in the interviews was that Chief Registrars were able to bring ideas from elsewhere. The peripatetic nature of their role has been reflected in the literature on the contribution of junior doctors to service improvement (Ibrahim *et al.,* 2013), and in our interviews, we heard that prior

7

experience from elsewhere was, for some, a significant contribution to both knowledge of how a service could be improved, and a motivator that it could be: *"[I have] take[n] a lead on developing an electronic take list. So that started from an idea ……. I worked somewhere else where we did this type of way of working"* (CR).

Medical engagement

A number of the activities reported in the survey related to general issue of engagement, for example establishing 'Mess meetings', coaching and mentoring trainees, or setting up newsletters of intranet pages for junior doctors. In many cases medical engagement was improved, although not without a *"struggle"* as *"tensions were already running very high"* among juniors (CR).

The 2016 junior doctor contract required that each provider organisation have a junior doctor forum. Chief Registrars often took the lead in facilitating the fora. In some cases, the state of relations between the organisation and juniors was poor and the Chief Registrar was seen as a mechanism by which it could be improved. *"When I came into the [organisation], it was struggling. They asked me for a role like this [junior doctor forum] because they had years and years of poor feedback from the deanery and they were under the equivalent of special measures [for] training and to the point where the deanery was threatening to take away their junior doctors"* (CR). Some Chief Registrars reported positive developments regarding medical engagement but only after a period of time *"So it took us a couple of months for that kind of thing to settle in. But by the end of it we definitely felt like we were a liaison"* (CR). One Chief Registrar suggested that the fora could have turned into a "whinge-fest", but where they were involved, they were able to influence them to become genuine processes of engagement.

Chief Registrars also acted as an informal liaison between juniors and seniors within the organisation. This `bridge' role allowed a two-way flow of information. A number of mechanisms were identified, including a `registrars' breakfast club' which ran weekly, informal mess meetings, and an informal network, so *'there's a registrar [in] oncology, anaesthetics and surgery… and we formed a little group and each person goes to a board meeting, there's a [person] designated to kind of be that junior doctor liaison from the senior management and the juniors"* (CR). Many identified an informal role in mentoring junior doctors, particularly but not exclusively, in quality improvement projects.

Junior and senior colleagues of Chief Registrars identified the benefits of these engagement activities. A junior doctor said that *"I think the first stage is acknowledgement and being listened to and I definitely think that's happened"* (JD). Similarly a Chief of Service said *"I've noticed increased engagement and it's definitely brought down barriers in terms of being able to communicate with them"* (CD).

Assessing impact

The difficulties of assessing impact was noted by all Chief Registrars. For example: *"It's very difficult to define and to put down on a piece of paper really, the whole experience, and to attempt to kind of quantify it in the way we deal with evidence normally is really difficult"* (CR). Nonetheless, some specific outcomes were cited by Chief Registrars in the evaluation. The Royal College of Physicians have published a Year book with individual stories (Royal College of Physicians 2017), and a number of abstracts have also been published in the Future Hospital Journal (Snelling and Exworthy, 2017).

While making contributions to leadership and service improvement, the Chief Registrar posts are also development posts. In interviews with senior medical colleagues, the training purpose of the

role was a stronger theme than the leadership and service improvement role. For example, one clinical director said that *"…the leadership in [the organisation] is also a positive although it's a learning role …they are leaders for the future …more than they are leaders for now I think"* (CD).

Some senior medical leaders explored the idea of 'exposing' Chief Registrars to a wide range of experiences, and in one case at least there was a view that this exposure might have been enhanced. A number of Chief Registrars were encouraged to attend Board meetings. However, the emphasis from both senior medical leaders and Chief Registrars was clearly on learning through undertaking a genuine leadership role. One Chief Registrar developed this theme of learning by doing rather than by observation: *"So I ended up going to all the meetings but then I just realised I spent all day in meetings and then once I had some ideas, I very quickly stopped going to the meetings, because I thought right I can just get on with these things now"* (CR).

The issue of the availability of time as a key enabler of leadership and learning was widely acknowledged. This related to individual projects where, in some cases, there was a realisation of the complexity of leading a process of change rather than just implementing a change. For example, one Chief Registrar explained learning about:

> *"…the things you have to do in order to effect change, the things you have to put into place first and people you have to speak to, the people you have to get on-board with change"* (CR).

In describing outcomes of their learning two themes are noteworthy. The first was in the structures and process in the NHS: *"In terms of the world or the environment of NHS management, before I started I knew absolutely nothing and it just seemed to be a new language and I think I still have a lot to learn but I'm getting to grips with how the NHS works"* (CR).

The second learning outcome, and the strongest theme, concerned the relational aspects of leadership and management. This included having the confidence to engage with colleagues, stating a viewpoint, and also the confidence not to lead on every initiative but to encourage colleagues to take action themselves.

Discussion

Two findings from this evaluation of the Chief Registrar scheme reflect the limited literature on Chief Resident schemes from America. Berg and Huot (2007) found that most Chief Resident posts in America operate on an annual cycle, showing a common evolution over each quarter of the year: (i) authorising and negotiating boundaries, (ii) problem solving, (iii) surviving (as the energy and drive dissipates), and (iv) transitioning and preparing to leave. This pattern was, broadly, repeated in our Chief Registrar case studies. During the initial periods, there was some uncertainty, and concern, about the role and its expectation, which was reflected in some nervousness abut the title of Chief Registrar. Second, Warner *et al.,* (2007) described Chief Residents' leadership style as "participating" (64%) rather than "coaching" (19%) or "delegating" (17%) Here, the participating style refers to "a greater emphasis on the relationships than the end task as it is expected that individuals are already quite aware of their end goal". (p.274). Again, this finding is reflected in our case studies.

We identified two dimensions along which the roles of Chief Registrar varied, in terms of their emphasis:

- between roles which are more clearly orientated to service improvement working on a range of specific projects, and roles which were more focussed on general leadership of with junior doctors.
- between roles which were seen as development posts, the primary aim of which was to support the development of the individual, and those which were substantial leadership roles with clearer expectations, especially by the Chief Registrars themselves.

These distinctions give rise to 4 categories of Chief Registrar role, which are presented in Figure 1 below. We identified Chief Registrars that seemed to fit in all four categories, at some part of their Chief Registrar role. As noted above, many Chief Registrars took some time to become established in the role, and so there is likely to have been movement between quadrants over the period of the role. These categories are offered as a way of exploring how the roles were enacted, to highlight the variation within the scheme, and particularly to locate the scheme within the literature on hybridity.

Figure 1 here

The idea of a hybrid leader is a concept widely used in the literature on medical leadership (Llewelyn 2001, Fulop 2012, Byrkjeflot and Jespersen 2014). This is normally considered in terms of the hybridity of managerial and clinical roles, and is applied to medical leaders, such as Clinical Directors, who maintain both. Chief Registrars add another dimension of hybridity, between a trainee and a medical leader, and in some cases where the Chief Registrar role was undertaken by a very senior trainee, between a trainee and a Consultant. The relationship between clinical work and the leadership role is a clear theme in the interviews, and supports claims for the distinctiveness of the scheme, with at least 40% of time developed to the Chief Registrar role.

A number of studies have considered hybrid leaders from the theory of social identity, and the extent to which their willingness and ability to take on new identities shapes their enactment of role (Cascon-Pereira and Hallier 2012, Spyridonidis *et al.,* 2014, Sartirana *et al.,* 2019). McGivern *et al.* (2015) distinguished between incidental and willing hybrids among medical leaders. Incidental hybrids occupy temporary positions and thereby seek to represent and protect traditional forms of medical professionalism. Willing hybrids see their role as a more secure position, possibly as a (permanent) career move. Formative roles and experience early in the career can shape whether individuals develop incidental or willing hybrid roles. Bresnen *et al.* (2019) came to similar conclusions, identifying three categories of hybrid leader based on identity formation; aspirational, ambivalent, and agnostic. Their study included medical leaders and other clinical leaders, and suggested that identity formation is more fluid than had previously been suggested. While it might be expected that Registrars choosing to undertake a Chief Registrar role may be willing or aspirational hybrid medical leaders, the extent to which the Chief Registrar scheme might be seen as a process of development of leadership identity (Andersson 2015) is an important one, which is considered in more detail in a publication under preparation.

Strengths and weaknesses of the scheme and the evaluation

It is very difficult to make empirical generalisations from a group in which there was significant variation in key elements of their roles. As the first, self-selected, cohort there may also be selection bias for both the Registrars themselves and the organisations who established the posts which would make the pilot scheme atypical of subsequent years. The leadership development programme which is a key element of the scheme was not considered in detail for this evaluation. As a pilot scheme, there may also have been a sense of participants projecting a positive image of their experiences to encourage its subsequent development, notwithstanding the uncertainty some felt in a new post. The evaluation was also limited to the period of the first cohort – there was no follow up

of projects undertaken, and so the sustainability of changes made was not assessed, and nor was any 'handover' to following appointments who may have different priorities, and may be in a different speciality.

The Chief Registrar scheme was established by the Royal College of Physicians who invested in the leadership development programme. The ambition of the Future Hospital Report was that each hospital would have a Chief Registrar in the medical specialties. The scheme has progressed with the current year's cohort (2019/20) being the fourth, with 71 Chief Registrars in 43 organisations. The 2019/20 scheme was open to all specialties, not just the medical specialties, and employing organisations needed to contribute to the cost of the development programme (Royal College of Physicians, 2019). Thus the scheme has developed from its original focus specifically on the Future Hospital Report to a broader leadership development programme.

The autonomy of local organisations and the Chief Registrars themselves to develop the roles may be seen as both a strength and a weakness of the scheme. A programme which allows participants to remain in clinical practice, and to remain in medical training, adds to the options available for leadership development. This was a limited evaluation, and a greater range and depth of case studies would have enhanced the results. However, conceptually, the typology of Chief Registrar roles was applied usefully to our data.

Conclusion

The evaluation of the Chief Registrar programme paints a picture of a group of medical leaders with a shared positive outlook and commitment to improving services through engaging with colleagues, both managerial and clinical. We highlight variation in the way that the roles were enacted, and difficulties in evaluating attributed impact in the short term. A number of detailed recommendations were made to the Royal College to help the development of the scheme, which has been achieved since the pilot year, evidenced in the numbers of appointments made. The positive developmental impact on the Chief Registrars themselves is clear. The distinctive feature of the scheme compared to a range of leadership fellowships available is that Chief Registrars remain in clinical practice, and for some within their training programmes. The scheme therefore provides experiences of hybrid medical leadership, with tensions between clinical and leadership work evident. Whether this provides a more effective preparation for future hybrid medical leaders is an issue that might be addressed in the future as the first cohorts progress in their careers.

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Table 1: Chief Registrars' activities

	Mean	Maximum	Minimum
Mean hours/month engaging with:			
Trainees	8.7	13.0	4.8
Senior Medical Staff	5.0	8.8	2.3
Other Clinical Staff	3.8	6.7	1.5
Other Clinical Staff Management	3.6	5.5	1.7
General Management staff	4.1	10.0	0.7
Executive staff	2.9	5.0	1.3
Other staff in the organisation	2.1	3.7	0.0
Other staff outside the organisation	2.4	3.6	0.7
% of time working on:			
Educational issues	26.7	39.3	16.7
Operational issues	19.7	57.1	7.1
Service improvement	46.5	65.7	22.9
Other issues	7.1	16.7	0.0

Table 2: Example of Chief Registrars' activities

Operational Issues

- Implementing a new rota and addressing rota gaps.
- Involvement in Deanery/GMC/CQC visits.
- Operational planning including predictive analysis.
- Evaluation of staffing to reduce agency spend.
- Establishing an ambulatory care unit
- Setting up a new Healthcare Informatics group
- Roll out of e-prescribing

Education

- Arranging and chairing Grand Round programme.
- Introducing simulation training.
- Addressing feedback for Junior Doctors' surveys.
- Working with undergraduate teaching and assessment

Service improvement

- Establishing QI Forum and teaching programme.
- Improving hospital discharges at weekend.
- Improving ward round note keeping.
- E-system for 'take lists' and 'review lists'.
- Improving ward rounds.
- "100% days" for 4 hours A&E target.
- Improving NEWS policy and escalation of high scores
- Developing 'ceiling of treatment' procedures
- Improving mental health liaison services
- Acute hospital at home
- Improving flow by matching medical hours to demand

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Figure 1 Typology of Chief Registrar roles